DEPARTMENT OF THE NAVY
NAVAL HOSPITAL
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MARINE CORPS AIR GROUND COMBAT CENTER
TWENTYNINE PALMS, CALIFORNIA 92278-8250

IN REPLY REFER TO:
NAVHOSP29PALMSINST 6320.64D
Code 0301
25 Aug 99

NAVAL HOSPITAL TWENTYNINE PALMS INSTRUCTION 6320.64D

From: Commanding Officer

Subj: MEDICAL RECORD REVIEW COMMITTEE

Ref: (a) Comprehensive Accreditation Manual for Hospitals, Joint Commission on Accreditation of Healthcare Organizations
(b) MANMED, Chapter 16
(c) NAVHOSP29PALMSINST 6320.5D
(d) NAVHOSP29PALMSINST 6300.1
(e) BUMEDINST 6010.13
(f) BUMEDINST 6010.17A
(g) NAVHOSP29PALMSINST 6010.9C

Encl: (1) Inpatient Medical Record Review 1st Quarter
(2) Inpatient Medical Record Review 2nd Quarter
(3) Inpatient Medical Record Review 3rd Quarter
(4) Inpatient Medical Record Review 4th Quarter
(5) Operative and Invasive Procedures Medical Record Review
(6) Outpatient Medical Record Review Form
(7) Emergency Care Record Review Form

1. Purpose. To establish a Medical Record Review Committee in order to ensure that the requirement of references (a) through (g) are met. This instruction has been completely revised and should be read in its entirety.

2. Cancellation. NAVHOSP29PALMSINST 6320.64C.

3. Background. References (a) and (b) require that the medical record contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among health care providers.

4. Policy. The Medical Record Review Committee (MRRC) will perform and document reviews of inpatient, operative and invasive procedure, outpatient, and emergency care medical records as noted below:

a. Inpatient Medical Record:

(1) Medical records are reviewed at least quarterly for completeness, accuracy, and timely completion of information, and action is taken as necessary to improve the process.

(2) The review is performed by, at a minimum, the medical staff in cooperation with nursing, the medical records department, management and administrative services, and representatives of other departments as appropriate.

(3) The review determines that each medical record, or a representative sample of records, is included in the review process.

(4) The review of medical records addresses the presence, accuracy, timeliness, legibility, and authentication of the data and information noted on enclosures (1) through (4). Additional items for review may be added to the quarterly reviews as deemed necessary by the Chair, MRRC.

(5) A inpatient medical record is considered delinquent when it has not been completed within 30 days following discharge.

(6) Enclosures (1) through (4) constitute the quarterly review of medical records. It is expected that within a 12-month period all items will have been subject to review. In addition, there will be a mechanism to ensure that reviews of medical records for each member of the medical staff are reviewed at least annually.

(7) A review of inpatient medical records will be conducted during the second and fourth quarter for all providers credentialled less than six months to address items in previous quarterly reviews and place them on the same schedule as other providers. The monthly committee minutes will contain a listing of all providers whose charts have been reviewed for tracking purposes.

(8) When the medical record review is based on a representative sample (a sample representing the practitioners

providing care and of the care provided,) the review encompasses hospitals full scope of practice, including the most common diagnoses and procedures, and all high-risk procedures. Samples include records of patients currently in the hospital (concurrent review) and completed records of discharged patients (closed review.)

b. Operative and Invasive Procedure Medical Records:

(1) In addition to the information required in all medical records, all aspects of a surgical patient's preoperative, operative, and postoperative care are documented.

(2) This includes operative, other invasive and noninvasive procedures such as CAT Scan, MRI, etc., which may place the patient at risk. The focus here is on procedures and therefore is not meant to include medications that may place patients at risk.

(3) The postoperative documentation includes at least the data and information noted on enclosure (5).

c. Outpatient Medical Record:

(1) Patients sometimes receive ambulatory care services on a continuing basis, and often from more than one provider. To promote continuity of care, both over time and among providers, a "Problem Summary List" will be maintained for any patient who is seen at three or more outpatient visits.

(2) The problem summary list is initiated for each patient by the third visit and maintained thereafter.

(3) The problem summary list includes the information noted on enclosure (6).

d. Emergency Medical Record:

(1) The medical records of patients who have received emergency care contain not only the information required of all medical records, but additional information specific to the emergency visit as noted on enclosure (7).

5. Medical Record Review Committee Organization

a. The chairperson shall be a medical officer appointed by the Commanding Officer from recommendations provided by the Executive Committee of the Medical Staff (ECOMS).

b. The medical record review is performed in a collaborative fashion by the MRRC. Permanent members shall include:

(1) Medical Directorate Physician Representative
(2) Surgical Directorate Physician Representative
(3) Nursing Directorate Representative
(4) Head, Patient Administration Department
(5) Supervisor, Outpatient Medical Records Department
(6) Medical Records Administrator (MRA)
(7) Branch Medical Clinic China Lake Representative
(8) Military Sick Call Representative
(9) Ancillary Services Directorate Representative
(10) Occupational Health Representative

c. Attendance is mandatory. If a member is unable to attend, a representative from his/her respective department or directorate must attend.

d. The Chairperson may recommend additional permanent members to the committee and appoint “ad hoc” members at any time. Additionally, the Chairperson has the authority to request assistance with the performance of approved committee business from any department, committee or individual.

6. Responsibilities

a. Medical Record Review Committee (MRRC) shall:

(1) Meet monthly.

(2) Conduct medical record reviews in the following categories at least quarterly:

(a) Inpatient Medical Records

(b) Outpatient Medical Records

(c) Operative and Invasive Procedures Medical Records

(d) Emergency Care Medical Records

(3) Serve as an educational resource in medical record matters.

(4) Coordinate performance improvement activities relating to medical record documentation including record reviews by the MRRC, Risk Management, Utilization Management and other designated groups to identify opportunities for improvement as per reference (g).

(5) Recommend and initiate actions, assess the effectiveness of the actions, and report findings to ECOMS, medical staff departments, the Performance Improvement Division, and others.

(6) Document conclusions, recommendations, actions, and follow-up monitoring in the minutes of each meeting and forward to ECOMS and the Performance Improvement Division for integration with medical and performance improvement activities.

(7) Provide periodic education to the Medical Staff by providing ECOMS with routine reports.

(8) Annually review this instruction, revise it as needed and forward recommendations to the ECOMS.

(9) Perform such other functions as may be required to ensure compliance with references (a) through (g) and to protect the interest of the patient, the practitioner and the hospital.

(10) Report to the Board of Directors (BOD) and ECOMS on a quarterly basis the following:

(a) The number and percentage of total records reviewed.

(b) The problems identified by noncompliance to standards, corrective action taken, the date the problem will be reviewed to ensure that the problem has been corrected, and who is responsible for that review.

(11) Submit committee minutes to the Commanding Officer via the Performance Improvement Coordinator, Chair, Executive Committee of the Medical Staff and the Executive Officer.

b. Patient Administration Department shall:

(1) Provide the MRRC with delinquency statistical information and report as necessary to assure the timely and appropriate completion of all medical records. A medical record is considered delinquent when it has not been completed within 30 days. The hospital measures its performance by assessing three areas of delinquency in medical records; overall completion, report of the history and physical examination, and operative reports.

(2) The hospital measures medical record delinquency at regular intervals, no less frequently than every three months, and reports the data as part of the medical record review function. Written reports are due to the Chair, MRRC no later than the 15th day of the first month of the quarter for the previous quarter. Delinquency rates are tracked by using the time frame of 30 days for medical record delinquency as specified in reference (c) and asking the following questions:

(a) What is the average monthly discharge (AMD) rate for inpatients during the past 12 months?

(b) What is the average monthly operative procedures (AMOP) rate for inpatients and outpatients for which an operative report is required?

(3) The Supervisor, Outpatient Medical Records Department will review and provide training to all areas that have outpatient records, as needed, but at least semi-annually.

(4) The MRA will review and provide training to all areas that have inpatient medical records, as needed, but at least semi-annually.

(5) The MRA will conduct an annual survey of all secondary records and report results of this survey to the Chair, MRRC no later than 15 Oct annually for the previous fiscal year.

7. Medical Record Review Methodology. The Chairman, MRRC will facilitate the review of the medical records.

a. Inpatient medical record reviews will be conducted during the 1st month of each quarter. Each review will consist of 10% of the average monthly discharges or 30 records, which ever is greater.

b. Operative and invasive procedures medical record reviews will be conducted during the 2nd month of each quarter. Each review will consist of 10% of the average monthly operative procedures or 30 records, whichever is greater.

c. Outpatient and emergency care medical record reviews will be conducted during the 3rd month of each quarter. Reviews will consist of 25 records in each category at a minimum.

d. The Chair, MRRC will distribute the assembled medical records to those participating in the review at the monthly meeting.

e. The participants will review the records for compliance with the items listed on the appropriate review form.

f. As each review form is completed, it will be given to the Chair, MRRC. The Chair, MRRC will tally the results of the record review and complete a summary report for inclusion with the monthly meeting minutes.

8. Applicability. The provision of this instruction applies to the Naval Hospital Twentynine Palms and Branch Medical Clinic China Lake.

J. M. Huber

J. M. HUBER

Distribution A

INPATIENT MEDICAL RECORD REVIEW
1ST QUARTER
Date

Reviewer:_____ Title:_____

Medical Record Number:_____ Provider:_____

The following items are required, as per Joint Commission Standard IM.3.2.1, to be included as part of the hospital's ongoing review of medical records. The review must address the **presence, accuracy, timeliness, legibility, and authentication of the items listed below**.

Item	Yes	No	N/A	Comments
Identification data.				
Medical history including the chief complaint; details of present illness; relevant past, social and family histories (appropriate to the patient's age); and an inventory of body system.				
A summary of the patient's psychosocial needs, as appropriate to the patient's age.				
A report of relevant physical examinations.				
A statement on the conclusions or impressions drawn from the admission history and physical examination.				

Closed Medical Record Review:_____

Check one:

Concurrent Medical Record Review

Retrospective Medical Record Review

INPATIENT MEDICAL RECORD REVIEW
1ST QUARTER
JCAHO Standards, Intents, and Examples for Patient Specific Data and Information

Indicate "yes" on the Inpatient Medical Record Review form if all items listed in the intent are in compliance with the JCAHO standards.

Indicate "no" on the Inpatient Medical Record Review form if one or more of the items in the intent are not in compliance with the JCAHO standards.

Item/JCAHO Standard	Intent
Identification data. (IM.7.2)	To facilitate consistency and continuity in patient care, the medical record contains very specific data and information, including the patient's name, address, date of birth, the name of any legally authorized representative, and evidence of known advance directives.
Medical history including the chief complaint; details of present illness; relevant past, social and family histories (appropriate to the patient's age); and an inventory of body system. (IM.7.6, PE.1, PE.1.6.1 and PE.1.6.1.1)	Each patient's medical history and physical examination are documented in his or her medical record within 24 hours of admission. This time frame applies for weekend, holiday, and weekday admissions. A durable, legible original or reproduction of a medical history and completed physical examination that is completed or thoroughly updated within 30 days before admission is acceptable if the patient's condition did not significantly change during the period between documentation of the history and physical examination and admission to the hospital. Significant changes are recorded at the time of admission.
A summary of the patient's psychosocial needs, as appropriate to the patient's age. (PE.1)	The initial assessment takes into account not only the patient's physiological status but psychological and social concerns.
A report of relevant physical examinations. (IM.7.6, PE.1.6.1, and PE.1.6.1.1)	Each patient's physical examination is documented in the medical record within 24 hours of admission. This time frame applies for weekend, holiday, and weekday admissions. A durable, legible original or reproduction of a completed physical examination that is completed or thoroughly updated within 30 days before admission is acceptable if the patient's condition did not significantly change during the period between documentation of the physical examination and admission to the hospital. Significant changes are recorded at the time of admission.
A statement on the conclusions or impressions drawn from the admission history and physical examination. (PE.3.1 and IM.7.2)	A patient may undergo many kinds of assessments from his or her physician and several other disciplines. As a result, there may be a variety of data, analyses, and other information in the patient's record. To facilitate consistency and continuity in patient care, the medical record contains conclusions or impressions drawn from the medical history and physical examination.

INPATIENT MEDICAL RECORD REVIEW
1ST QUARTER SUMMARY
Date

Total Number of Records Reviewed: _____

Type of Review: _____

Type of Records: _____

Item	Yes	No	N/A	% Compliance
Identification data.				
Medical history including the chief complaint; details of present illness; relevant past, social and family histories (appropriate to the patient's age); and an inventory of body system.				
A summary of the patient's psychosocial needs, as appropriate to the patient's age.				
A report of relevant physical examinations.				
A statement on the conclusions or impressions drawn from the admission history and physical examination.				

Closed Medical Records Reviewed: _____

Concurrent Medical Records Reviewed: _____

INPATIENT MEDICAL RECORD REVIEW
2nd QUARTER
Date

Reviewer:_____ Title:_____

Medical Record Number:_____ Provider:_____

The following items are required, as per Joint Commission Standard IM.3.2.1, to be included as part of the hospital's ongoing review of medical records. The review must address the **presence, accuracy, timeliness, legibility, and authentication of the items listed below**.

Item	Yes	No	N/A	Comments
A statement on the course of action planned for the patient for this episode of care and of its periodic review, as appropriate.				
Diagnostic and therapeutic orders.				
Evidence of appropriate informed consent.				
Clinical observations, including the results of therapy.				
Progress notes made by the medical staff and other authorized staff.				

Closed Medical Record Review:_____

Check one:

Concurrent Medical Record Review

Retrospective Medical Record Review

INPATIENT MEDICAL RECORD REVIEW
2nd QUARTER
JCAHO Standards, Intents, and Examples for Patient Specific Data and Information

Indicate "yes" on the Inpatient Medical Record Review form if all items listed in the intent are in compliance with the JCAHO standards.

Indicate "no" on the Inpatient Medical Record Review form if one or more of the items in the intent are not in compliance with the JCAHO standards.

Item/JCAHO Standard	Intent
A statement on the course of action planned for the patient for this episode of care and of its periodic review, as appropriate. (TX.1, TX.1.1, TX.1.1.1, TX.1.2, and TX.1.3)	Care is planned to respond to each patient's unique needs (including age-specific needs), expectations, and characteristics with effective, efficient, and individualized care. Care, treatment, and rehabilitation are planned to ensure that they are appropriate to the patient's needs and severity of disease, condition, impairment, or disability. Settings and services required to meet patient care goals are identified, planned and provided if appropriate. When patient care is not planned to meet all identified needs, this is documented in the medical record. The patients' progress is periodically evaluated against care goals and the plan of care and when indicated, the plan or goals are revised.
Diagnostic and therapeutic orders. (IM.7.2)	All diagnostic and therapeutic orders such as diet orders, and clinical observations such as height and weight, are documented in the patient's medical record.
Evidence of appropriate informed consent. (IM.7.2)	Evidence of informed consent when required by hospital policy.
Clinical observations, including the results of therapy. (IM.7.2)	To facilitate consistency and continuity in patient care, the medical record contains clinical observations including the results of therapy.
Progress notes made by the medical staff and other authorized staff. (IM.7.2)	To facilitate consistency and continuity in patient care, the medical record contains progress notes made by the medical staff and other authorized individuals.

INPATIENT MEDICAL RECORD REVIEW
2nd QUARTER SUMMARY
Date

Total Number of Records Reviewed: _____

Type of Review: _____

Type of Records: _____

Item	Yes	No	N/A	% Compliance
A statement on the course of action planned for the patient for this episode of care and of its periodic review, as appropriate.				
Diagnostic and therapeutic orders.				
Evidence of appropriate informed consent.				
Clinical observations, including the results of therapy.				
Progress notes made by the medical staff and other authorized staff.				

Closed Medical Records Reviewed: _____

Concurrent Medical Records Reviewed: _____

INPATIENT MEDICAL RECORD REVIEW
3rd QUARTER
Date

Reviewer:_____ Title:_____

Medical Record Number:_____ Provider:_____

The following items are required, as per Joint Commission Standard IM.3.2.1, to be included as part of the hospital's ongoing review of medical records. The review must address the **presence, accuracy, timeliness, legibility, and authentication of the items listed below**.

Item	Yes	No	N/A	Comments
Consultation reports.				
Reports of operative and other invasive procedures, tests, and their results.				
Reports of diagnostic and therapeutic procedures, such as pathology and clinical laboratory examinations and radiology and nuclear medicine examinations or treatment.				
Records of donation and receipt of transplants or implants.				
Final diagnosis(es).				

Closed Medical Record Review:_____

Check one:

Concurrent Medical Record Review

Retrospective Medical Record Review

INPATIENT MEDICAL RECORD REVIEW
3rd QUARTER
JCAHO Standards, Intents, and Examples for Patient Specific Data and Information

Indicate "yes" on the Inpatient Medical Record Review form if all items listed in the intent are in compliance with the JCAHO standards.

Indicate "no" on the Inpatient Medical Record Review form if one or more of the items in the intent are not in compliance with the JCAHO standards.

Item/JCAHO Standard	Intent
Consultation reports. (IM.7.2, CC.1, and CC.5)	If the hospital does not offer services directly, they provide for their availability and the patient's access to the services. To facilitate consistency and continuity in patient care, the medical record contains consultation reports.
Reports of operative and other invasive procedures, tests, and their results. (IM.7.3.2)	Operative reports dictated or written immediately after surgery record the name of the primary surgeon and assistants, findings, technical procedures used, specimens removed, and postoperative diagnosis.
Reports of diagnostic and therapeutic procedures, such as pathology and clinical laboratory examinations and radiology and nuclear medicine examinations or treatment. (IM.7.2)	To facilitate consistency and continuity in patient care, the medical record contains all diagnostic and therapeutic procedures and test results.
Records of donation and receipt of transplants or implants. (IM.3.2.1)	To facilitate consistency and continuity in patient care, the medical record contains records of donation and receipt of transplants or implants.
Final diagnosis(es). (IM.7.6)	All final diagnoses and complications are recorded without the use of symbols or abbreviations.

INPATIENT MEDICAL RECORD REVIEW
3rd QUARTER SUMMARY
Date

Total Number of Records Reviewed: _____

Type of Review: _____

Type of Records: _____

Item	Yes	No	N/A	% Compliance
Consultation reports.				
Reports of operative and other invasive procedures, tests, and their results.				
Reports of diagnostic and therapeutic procedures, such as pathology and clinical laboratory examinations and radiology and nuclear medicine examinations or treatment.				
Records of donation and receipt of transplants or implants.				
Final diagnosis(es).				

Closed Medical Records Reviewed: _____

Concurrent Medical Records Reviewed: _____

INPATIENT MEDICAL RECORD REVIEW
4th QUARTER
Date

Reviewer:_____ Title:_____

Medical Record Number:_____ Provider:_____

The following items are required, as per Joint Commission Standard IM.3.2.1, to be included as part of the hospital's ongoing review of medical records. The review must address the **presence, accuracy, timeliness, legibility, and authentication of the items listed below**.

Item	Yes	No	N/A	Comments
Conclusions at termination of hospitalization.				
Clinical resumes and discharge summaries.				
Discharge instructions to the patient or family.				
When performed, results of autopsy.				

Closed Medical Record Review:_____

Check one:

Concurrent Medical Record Review

Retrospective Medical Record Review

INPATIENT MEDICAL RECORD REVIEW
4th QUARTER
JCAHO Standards, Intents, and Examples for Patient Specific Data and Information

Indicate “yes” on the Inpatient Medical Record Review form if all items listed in the intent are in compliance with the JCAHO standards.

Indicate “no” on the Inpatient Medical Record Review form if one or more of the items in the intent are not in compliance with the JCAHO standards.

Item/JCAHO Standard	Intent
Conclusions at termination of hospitalization. (IM.7.2)	To facilitate consistency and continuity in patient care, the medical record contains conclusions at termination of hospitalization.
Clinical resumes and discharge summaries. (IM.7.2)	A concise clinical resume included in the medical record at discharge provides important information to other caregivers and facilitates continuity of care. For patients discharged to ambulatory care, the clinical resume summarizes previous levels of care. The discharge summary contains the following information: 1. The reason for hospitalization; 2. Significant findings; 3. Procedures performed and treatment rendered; 4. The patient’s condition at discharge, and 5. Instructions to the patient and family, if any.
Discharge instructions to the patient or family. (IM.7.2)	To facilitate consistency and continuity in patient care, the medical record contains discharge instructions to the patient or family
When performed, results of autopsy. (IM.7.6)	When an autopsy is performed, provisional anatomic diagnoses are recorded in the medical record within 3 days, and the complete protocol is included in the medical record within 60 days, unless the medical staff establishes exceptions for special studies.

INPATIENT MEDICAL RECORD REVIEW
4th QUARTER SUMMARY
Date

Total Number of Records Reviewed: _____

Type of Review: _____

Type of Records: _____

Item	Yes	No	N/A	Comments
Conclusions at termination of hospitalization.				
Clinical resumes and discharge summaries.				
Discharge instructions to the patient or family.				
When performed, results of autopsy.				

Closed Medical Records Reviewed: _____

Concurrent Medical Records Reviewed: _____

OPERATIVE AND INVASIVE PROCEDURES
MEDICAL RECORD REVIEW
Date

Reviewer:_____ Title:_____

Medical Record Number:_____ Provider:_____

In addition to the information required in all medical records, the hospital documents all aspects of a surgical patient's preoperative, operative, and postoperative care. Operative and other procedures includes operative, other invasive, and noninvasive procedures such as radiotherapy, CAT scan, and MRI, that may place the patient at risk. This requirement applies to outpatient as well as inpatients. The following items are required, as per Joint Commission Standard IM.7.3 through IM.7.3.5.

Item	Yes	No	N/A	Comments
The licensed independent practitioner responsible for the patient records a preoperative diagnosis before surgery.				
Operative reports dictated or written immediately after surgery record the name of the primary surgeon and assistants, findings, technical procedures used, specimens removed, and postoperative diagnosis.				
The completed operative report is authenticated by the surgeon and filed in the medical record as soon as possible after the surgery.				
When the operative report is not placed in the medical record immediately after surgery, a progress note is entered immediately.				
Postoperative documentation records the patient's vital signs, and level of consciousness; medications (including intravenous fluids), blood, and blood components; any unusual events or postoperative complications; and management of such events.				
Compliance with discharge criteria is fully documented in the patient's medical record.				
Postoperative documentation records the name of the licensed independent practitioner responsible for discharge.				

OPERATIVE AND INVASIVE PROCEDURES
MEDICAL RECORD REVIEW
SUMMARY
Date

Total Number of Records Reviewed: _____

Type of Review: _____

Item	Yes	No	N/A	Comments
The licensed independent practitioner responsible for the patient records a preoperative diagnosis before surgery.				
Operative reports dictated or written immediately after surgery record the name of the primary surgeon and assistants, findings, technical procedures used, specimens removed, and postoperative diagnosis.				
The completed operative report is authenticated by the surgeon and filed in the medical record as soon as possible after the surgery.				
When the operative report is not placed in the medical record immediately after surgery, a progress note is entered immediately.				
Postoperative documentation records the patient's vital signs, and level of consciousness; medications (including intravenous fluids), blood, and blood components; any unusual events or postoperative complications; and management of such events.				
Compliance with discharge criteria is fully documented in the patient's medical record.				
Postoperative documentation records the name of the licensed independent practitioner responsible for discharge.				

Comments:

OUTPATIENT
MEDICAL RECORD REVIEW
Date

Reviewer:_____ Title:_____

Medical Record Number:_____ Provider:_____

For patients receiving continuing ambulatory care services, the medical record contains a summary list of known significant diagnoses, conditions, procedures, drug allergies, and medications. The following items are required, as per Joint Commission Standard IM.7.4 through IM.7.4.1.

Item	Yes	No	N/A	Comments
For patients receiving continuing ambulatory care services, the following are listed				
Known significant medical diagnoses and conditions;				
Known significant operative and invasive procedures;				
Medications known to be prescribed for or used by the patient.				
Known adverse and allergic drug reactions.				
The summary list is started by the third visit.				

Check one:

Concurrent Medical Record Review

Retrospective Medical Record Review

OUTPATIENT
MEDICAL RECORD REVIEW
SUMMARY
Date

Total Number of Records Reviewed: _____

Type of Review: _____

Item	Yes	No	N/A	% Compliance
For patients receiving continuing ambulatory care services, the following are listed				
Known significant medical diagnoses and conditions;				
Known significant operative and invasive procedures;				
Medications known to be prescribed for or used by the patient.				
Known adverse and allergic drug reactions.				
The summary list is started by the third visit.				

Closed Medical Records Reviewed: _____

Concurrent Medical Records Reviewed: _____

Comments:

EMERGENCY CARE
MEDICAL RECORD REVIEW
Date

Reviewer:_____ Title:_____

Medical Record Number:_____ Provider:_____

The medical records of patients who have received emergency care contain not only the information required of all medical records, but additional information specific to the emergency visit. The following items are required, as per Joint Commission Standard IM.7.5 through IM.7.5.3.

Item	Yes	No	N/A	Comments
Emergency care provided to the patient prior to arrival, if any, is documented.				
When emergency, urgent, or immediate care is provided, the time and means of arrival are also documented in the medical record.				
The medical record notes when a patient receiving emergency, urgent, or immediate care left against medical advice.				
Conclusions at the termination of treatment, including				
Final disposition;				
Condition at discharge; and				
Any instructions for follow-up care.				
Emergency patient transfers to other organizations include:				
Reason for transfer;				
Stability of patient;				
Acceptance by the receiving organization;				
Responsibility during transfer, and				
Relevant patient information accompanies the patient.				

EMERGENCY CARE
MEDICAL RECORD REVIEW
SUMMARY
Date

Total Number of Records Reviewed:_____

Type of Review:_____

Item	Yes	No	N/A	% Compliance
Emergency care provided to the patient prior to arrival, if any ,is documented.				
When emergency, urgent, or immediate care is provided, the time and means of arrival are also documented in the medical record.				
The medical record notes when a patient receiving emergency, urgent, or immediate care left against medical advice.				
Conclusions at the termination of treatment, including				
Final disposition;				
Condition at discharge; and				
Any instructions for follow-up care.				
Emergency patient transfers to other organizations include:				
Reason for transfer;				
Stability of patient;				
Acceptance by the receiving organization;				
Responsibility during transfer, and				
Relevant patient information accompanies the patient.				

Comments: